TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Bayshore Medical Center

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-16-2994-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 31, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In closing, it is the position of the Hospital that all charges relating to the admission of this claimant are due and payable and not subject to the improper reduction taken by the Carrier in this case. The Carrier's position is incorrect and in violation of Rule § 134.403."

Amount in Dispute: $17,575.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent requests Medical Fee Dispute Resolution enter a Findings and Decision stating Requestor waived their right to dispute resolution as the request was not filed within one year of the date of service."

Response Submitted by: Downs♦Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 28 – 29, 2015	Inpatient Hospital Services	$17,575.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §102.3 sets out guidelines for computation of time.
3. Texas Government Code §311 defines year.
4. Texas Government Code §662 defines national holiday.
5. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - W3 – Additional payment made on appeal/reconsideration
   - 193 – Original payment decision is being maintained

Issues

1. Is the respondent's position statement supported?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, "Respondent requests Medical Fee Dispute Resolution enter a Findings and Decision stating Requestor waived their right to dispute resolution as the request was not filed within one year of the date of service."

   28 Texas Administrative Code §133.307(c)(1) states:

   > Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   >
   > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than **one year after the date(s)** of service in dispute.

   The date of the services in dispute is May 28, 2015 through May 29, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on May 31, 2016.

   Texas Government Code §311.005(12) states in pertinent part, "Year" means 12 consecutive months.

   28 Texas Administrative Code §102.3(a)(2) and (3) states in pertinent parts,

   > (2) computing a period of months. If a number of months is to be computed by counting the months from a particular day, the period **ends on the same numerical day in the concluding month as the day of the month from which the computation is begun**, unless there are not that many days in the concluding month, in which case the period ends on the last day of that month.
   >
   > (3) unless otherwise specified, if the last day of any period is not a working day, **the period is extended to include the next day that is a working day**.

   28 Texas Administrative Code §102.3(b) states, A working day is any day, Monday – Friday, other than a national holiday as defined by Texas Government Code, §662.003(a) and the Friday after Thanksgiving Day, December 24th and December 26th. Use in this title of the term "day," rather than "working day" shall mean a calendar day.

   Texas Government Code §662.003 (a) states,

   > A national holiday includes only the following days:
   >
   > (4) the last Monday in May, "Memorial Day";

   As the last day was Sunday, May 29, 2016 this was not a working day. Monday, May 30, 2016 was a national holiday, therefore also not a working day. Pursuant to 28 Texas Administrative Code §102.3(3) the period to submit the services in dispute were extended to May 31, 2016. The request for Medical Dispute Resolution was timely. The requestor's position is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. This dispute regards the facility medical services of an inpatient acute care hospital with reimbursement subject to the provisions of Code 28 Texas Administrative Code §134.404(f), which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per §134.404(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

3. Per §134.404(f)(1)(A), the sum of the Medicare facility specific amount, including any outlier payment, is multiplied by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 354. The services were provided at Bayshore Medical Center. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $12,328.45. This amount multiplied by 143% results in a MAR of $17,629.68.

4. The total recommended payment for the services in dispute is $17,629.68. The insurance carrier has paid $17,629.67. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 27, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.